

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2620AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY ELDERCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2961 E SERENE AVE HENDERSON, NV 89014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 3/19/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 8 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 6. Six resident files were reviewed and 4 employee files were reviewed. The following deficiencies were identified:	Y 000		
Y 070 SS=F	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review on 3/19/09, the facility failed to ensure 2 of 4 caregivers received eight hours of annual training (Employee #2 and #3). Severity: 2 Scope: 3	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2620AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY ELDERCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2961 E SERENE AVE HENDERSON, NV 89014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 106 SS=D	<p>449.200(2)(a) Personnel File - 1st aid & CPR</p> <p>NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.</p> <p>This Regulation is not met as evidenced by: Based on record review on 3/19/09, the facility failed to ensure 1 of 4 caregivers were trained in first aid and cardiopulmonary resuscitation (Employee #3).</p> <p>Severity: 2 Scope: 1</p>	Y 106		
Y 859 SS=D	<p>449.274(5) Periodic Physical examination of a resident</p> <p>NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.</p>	Y 859		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2620AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY ELDERCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2961 E SERENE AVE HENDERSON, NV 89014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 859	Continued From page 2 This Regulation is not met as evidenced by: Based on record review on 3/19/09, the facility failed to ensure 2 of 6 residents received an annual physical (Resident #2 and #6). Severity: 2 Scope: 1	Y 859		
Y 870 SS=B	449.2742(1)(a)(1)(2)(b)(c) 449.2742(1)(a)(1) Medication Administration NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. (2) Provides a written report of that review to the administrator of the facility; (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).	Y 870		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2620AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2009
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY ELDERCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2961 E SERENE AVE HENDERSON, NV 89014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 870	Continued From page 3 This Regulation is not met as evidenced by: Based on record review on 3/19/09, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 2 of 6 residents residing at the facility for longer than six months (Resident #2 and #6). Severity: 1 Scope: 2	Y 870			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.